

**INITIAL PATIENT QUESTIONNAIRE**

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **AGE:** \_\_\_\_ **SSN:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **SEX:** M / F

**Home Address:** \_\_\_\_\_  
Street City State Zip

**Phone:** (H) \_\_\_\_\_ (Cell) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Emergency Contact & Relation:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**PATIENT INFORMED CONSENT**

State law requires offices to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you. What your being asked to sign is simply a confirmation that you have been informed of the following.

**EXAMINATIONS**

**X-RAYS:** This office uses highly sensitive x-ray film, intensifying screens and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only risk with taking x-rays deals with pregnancy. If there is any possibility that you are pregnant, inform us prior to any x-ray procedure. If there is no possibility of this condition, the risks are so rare we have no available statistics to qualify their probability.

**TREATMENT**

**Chiropractic adjustment/manipulation:** The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, this is not a cause for alarm. There are some material risks involved in doing these procedures they are as follows:

**Pain:** Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.

**Rib Fractures:** Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate and gentle treatments are used, minimizing the possibility of fractures to the ribs.

**Disc Injury:** Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems.\* Occasionally, chiropractic may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place risk of serious injury at about 1 serous complication per 100 million low back manipulations.\*\*

**Stroke:** The overall incidence of stroke in the general population is about 2 per 1000 people.\*\*\* Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke secondary to chiropractic adjustment/manipulation may occur in 1 per 100,000 patients \*\*\*\* - a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, Ibuprofen, Naproxen sodium, etc.) is 4 per 100,000 patients.\*\*\*\*\* The risk of serious complication or death from spine surgeries of the neck is 11.25 per 1000 patients.\*\*\*\*\* As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and test that will likely reduce the potential for stroke even more.

Chiropractic is a system of health care delivery. As with any health delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

If you have any questions on the above information, please ask the doctor. When you have a clear understanding, please sign and date below.

**I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM AND I HAVE BEEN INFORMED OF THE MOST LIKELY COMPLICATIONS, OF THE POSSIBLE UNDESIREED RESULTS OF CHIROPRACTIC EXAMINATION AND TREATMENT IN THIS OFFICE AND UNDERSTAND THEM. I HEREBY AUTHORIZE AND DIRECT DR. COBB AND HIS ASSOCIATES OR ASSISTANTS TO PROVIDE SUCH ADDITIONAL SERVICES AS THEY MAY DEEM REASONABLE AND NECESSARY.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

If patient is less than 18 years of age.

Parent's/Guardian's Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**References**

- \* Troyanovich SJ, Harrison DE. Low Back pain and the lumbar intervertebral disc: Clinical considerations for the doctor of chiropractic.
- \*\* Shekelle PG, Spine update: Spinal Manipulation, Spine 1994; 19; 858-86
- \*\*\* Clayman CB. The American Medical Association Home Encyclopedia. New York: Random House: 947-948
- \*\*\*\* Dabbs V, Lauretti WJ. Risk Assessment of Cervical Manipulation vs. NSAIDS for the treatment of neck pain. J Manipulative Physiol Ther 1995; 18:530-536.
- \*\*\*\*\* Harwitz EI, Aker PD, Adams AH, Meeker WC, Shekelle PG. Manipulation and mobilization of the cervical Spine: A systematic review of the literature, Spine 1996; 21: 1746-1760.

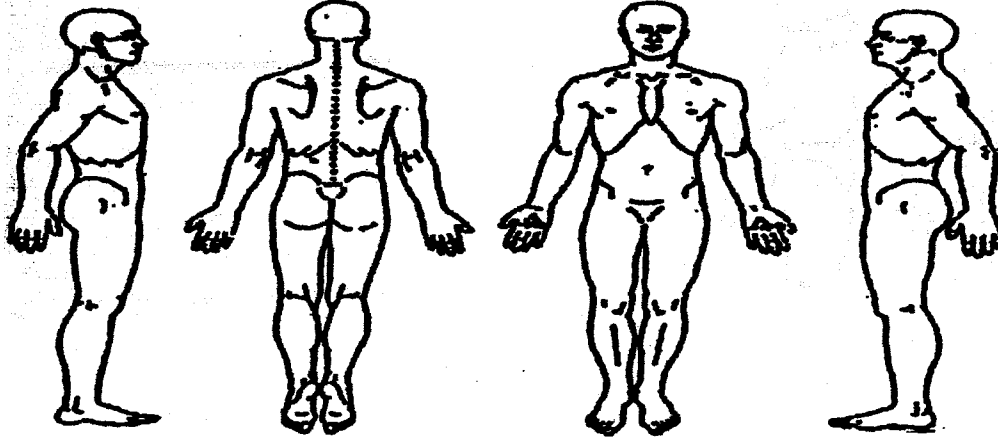
# PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident  Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)  Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)  Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp  Numb  
 Dull  Tingly  
 Diffuse  Sharp with motion  
 Achy  Shooting with motion  
 Burning  Stabbing with motion  
 Shooting  Electric like with motion  
 Stiff  Other: \_\_\_\_\_

5. How are your symptoms changing with time?

- Getting Worse  Staying the Same  Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

8. How much has the problem interfered with your social activities?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

9. Who else have you seen for your problem?

- Chiropractor  Neurologist  Primary Care Physician  
 ER physician  Orthopedist  Other: \_\_\_\_\_  
 Massage Therapist  Physical Therapist  No one

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes  Yes, at times  No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?



# Cobb Rehab and Wellness

4209 E. Busch Blvd.

Tampa, FL 33617

(813) 914-8500

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Guardian or Patient's legal representative

\_\_\_\_\_  
Signature

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.**



DR. GREGORY COBB

4209 E. BUSCH BLVD. TAMPA, FL 33617  
phone: (813) 914-8500 fax: (813) 914-8511  
cobbrehabwellness.com

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

# COBB REHAB & WELLNESS

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## HOW DID YOU HEAR ABOUT OUR CLINIC:

PPO-HMO Provider book: \_\_\_\_\_

Sign / Location: \_\_\_\_\_

Friend / Relative / Co-worker: \_\_\_\_\_

Yellow Pages: \_\_\_\_\_

Attorney: \_\_\_\_\_

Another Doctor / Clinic: \_\_\_\_\_

THANK YOU FOR CHOOSING *COBB REHAB & WELLNESS* FOR YOUR HEALTH CARE NEEDS.